

University of Arkansas, Fayetteville

ScholarWorks@UARK

The Eleanor Mann School of Nursing
Undergraduate Honors Theses

The Eleanor Mann School of Nursing

12-2019

Addressing Barriers to Maternal Healthcare for Marshallese Islanders in Northwest Arkansas: An Internship Experience

Victoria Richardson

Follow this and additional works at: <https://scholarworks.uark.edu/nursuht>



Part of the [Maternal, Child Health and Neonatal Nursing Commons](#), [Nursing Midwifery Commons](#), [Obstetrics and Gynecology Commons](#), and the [Public Health and Community Nursing Commons](#)

Citation

Richardson, V. (2019). Addressing Barriers to Maternal Healthcare for Marshallese Islanders in Northwest Arkansas: An Internship Experience. *The Eleanor Mann School of Nursing Undergraduate Honors Theses*. Retrieved from <https://scholarworks.uark.edu/nursuht/93>

This Thesis is brought to you for free and open access by the The Eleanor Mann School of Nursing at ScholarWorks@UARK. It has been accepted for inclusion in The Eleanor Mann School of Nursing Undergraduate Honors Theses by an authorized administrator of ScholarWorks@UARK. For more information, please contact ccmiddle@uark.edu.

Addressing Barriers to Maternal Healthcare for Marshallese Islanders in Northwest Arkansas:

An Internship Experience

Victoria Shea Richardson

University of Arkansas

NURS 498VH Honors Education Thesis

Abstract

The Marshallese community is a rapidly growing population in Northwest Arkansas. Approximately 12,000 people migrated from the Marshall Islands and settled in the state of Arkansas due to the signing of the Compact of Free Association (COFA) in 1986. Although the population in Northwest Arkansas is experiencing rapid growth, there are significant health disparities that coincide with it. Due to vast cultural differences, language barriers, low economic status, and political barriers, the Marshallese community suffers from prenatal health inequalities and poor maternal and fetal outcomes, including low birth-weight infants, premature births, and increased infant mortality. During my internship, I provided care for many Marshallese mothers and infants and saw these barriers firsthand. I gained nursing experience through every aspect of the birthing process and learned critical thinking, technical, and communication skills while shadowing my nurse. I analyzed fetal heart tones, assessed mothers' pain level and performed nursing interventions, assembled delivery tables and instruments, practiced therapeutic communication with my patients, and approached each labor uniquely. During my internship, I was able to interview Willow Creek Women's Hospital's Marshallese secretary, Kiki Beasha. In this interview, Kiki recounted her own experience with barriers while working at Willow Creek and offered possible solutions to the problem. Solutions such as policy reform, cultural competency training, hiring bilingual ancillary staff, and offering transportation options would help facilitate a positive change for Marshallese patients.

Maternal healthcare and prenatal care is of pressing importance in today's world. It becomes even more pressing to those who face unnecessary barriers and lack access to screening or treatment. This is the case for the Marshallese islanders in Northwest Arkansas. This community of people originated in the Marshall Islands off of the coast of Australia, coming to seek refuge and opportunity in the United States. The Marshall Islands were once under the United States' administrative control under the United Nations Trust Territory of the Pacific Islands from 1947 to 1986 (Ayers, Hawley, Purvis, Moore, & McElfish, 2018). After this period, the Compact of Free Association (COFA) was signed which made the Marshall Islands a sovereign nation and allowed the Marshallese people rights to freely travel to the United States to reside and work without the need for a visa or permanent resident card. Between the years 2000 to 2010, the population of the Marshallese community increased by 252% in the state of Arkansas, bringing the total population to nearly 12,000 people (Ayers, Hawley, et al., 2018). This community in Arkansas is one of the fastest growing group of immigrants in the nation, however, it has one of the highest rates of health disparities and lack of access to healthcare.

Due to vast cultural differences, social stigma, low economic status, and political barriers, the Marshallese community suffers from prenatal health inequalities and poor maternal and fetal outcomes. Growing rates of low birth-weight infants, preterm births, and infant mortality continue to impact this community despite efforts to fix the problem (Ayers, Hawley, et al., 2018). Although the number of Marshallese migrants in the Northwest Arkansas area is increasing, the percent of women who actually receive appropriate maternal care is slim.

As mentioned previously, a barrier to accessing maternal care for Marshallese women includes the lack of proper federal and state policies. Upon signing of the COFA in 1986,

Marshallese migrants were eligible for Medicaid when they traveled to the United States. After a decade, another federal document called the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) was signed in 1996 (Ayers, Hawley, et al., 2018). This act restricted COFA migrant adults from being eligible for Medicaid and children from being eligible for the Children's Health Insurance Program (CHIP) under federal law. The act left individual states the option to cover COFA people with their own state funds. Many states extended coverage options for COFA migrants, however, Arkansas opted out (McElfish, 2016). This means that many Marshallese people go uninsured or underinsured. According to research conducted by Pearl Anna McElfish in the *Journal of the Arkansas Medical Society*, approximately 50% of Marshallese living in Arkansas are uninsured (McElfish, 2016). Although adult, non-pregnant COFA migrants are not covered in Arkansas, pregnant COFA women are able to receive Medicaid, but the coverage is limited to the costs of delivering the child (Ayers, Hawley, et al., 2018). This deficit in coverage impacts the ability for Marshallese women to afford prenatal care, required medication, and any hospitalization during their pregnancy, as they would pay for all treatment out-of-pocket. The lack of coverage puts them at greater risk for health inequities, especially in terms of maternal healthcare, labor experience, and birth outcomes (Ayers, Hawley, et al., 2018).

Along with limited access to federal and state support, Marshallese women also face economic and structural barriers to receiving care. These barriers center around lack of transportation to receive prenatal care and the funds to pay for prenatal care and hospitalization. A community-based participatory research (CBPR) study, published in the *Maternal and Child Health Journal*, created focus groups of Marshallese mothers who discussed barriers they faced

when receiving prenatal care. Evidence showed that these women would delay or even forego prenatal care because they had no means to pay and no insurance to help (Ayers, Purvis, et al., 2018). It was also stated that “women would tell each other to ‘wait until your stomach hurts and it’s time for you to give birth and you can go because they’ll have to see you either way,’ because that’s the problem, it’s the money” (Ayers, Purvis, et al., 2018). Another restriction to accessing prenatal care lies in transportation. It was mentioned in this study by the participants that if they had a car, they would see their doctor; however, if they did not have a car or gas money, they would not go (Ayers, Purvis, et al., 2018). This statement stems from the fact that most Marshallese women live under the poverty level and people in their community work mainly in food-processing and service industries (McElfish, Hallgren, & Yamada, 2015). Having this lower socioeconomic status puts Marshallese women at a high care deficit and puts greater risk on their health and the health of their unborn children, which is reflected by higher rates of low birth-weight infants and other poor outcomes (McElfish, et al., 2015).

In addition to the economic and political health disparities, Marshallese women face innumerable deficits with language barriers, cultural differences, and social stigmas. Interviews with medical providers published in *Ethnicity & Health* stated “many Marshallese patients do not speak English, and those who do speak English have limited proficiency” (McElfish, Chughtai, Low, Garner, & Purvis, 2018). Marshallese is a language that is not translatable by any app or blue phone and it contains very few words, making it difficult to communicate with patients (McElfish, et al., 2018). Many times, providers must use a translator to communicate with patients, either by someone employed by the hospital or clinic, or by a family member. When a family member is interpreting, there is no way of knowing if the patient is receiving all of the

necessary information. Due to the limited vocabulary of the Marshallese language, intricacies of a medical conditions are also difficult to explain, as there are not certain words for specific organs or disease processes (McElfish, et al., 2018). In terms on non-verbal communication, Marshallese patients culturally remain stoic in the healthcare setting, which makes communicating a challenge (Ayers, Hawley, et al., 2018). Some providers mentioned difficulty assessing physical pain levels during childbirth. They wouldn't expect the mother to be in labor, however, a cervical exam would show they were completely dilated (Ayers, Hawley, et al., 2018). This also affects administration of epidurals or pain medications, as Marshallese women do not admit to any pain.

Culturally, the western healthcare system is vastly different than the Marshallese healthcare system. In Marshallese culture, patients tend to come in when they are very sick and do not practice preventative care (McElfish, et al., 2018). This is also applicable for lack of prenatal care as evidenced in the study by Ayers. Patients tend to come to the hospital in the third trimester, or even at the end stages of labor, right before they need to push, which makes it difficult to alert the provider. It also impacts the development of the fetus throughout the pregnancy because there is no screening done to check for gestational diabetes, congenital defects, or even gestational age (Ayers, Hawley, et al., 2018).

One of the greatest barriers in communication is the lack of connection to the patients due to social stigmas. One such stigma stems from perceived discrimination, which leads to embarrassment and shame in regards to age and marital status of the mother. Interview participants in the study by Ayers stated that there was a feeling of embarrassment associated with young or old age pregnancies, as well as stigmas with unmarried mothers because they

differed from US culture norms (Ayers, Purvis, et al., 2018). Fear is associated with this feeling of embarrassment, however, it is also associated with the possibility of hearing bad news about their health. In the interview by Ayers, Marshallese participants said they were afraid that they would hear something bad happened to the baby, afraid that they could not understand the doctor, fear of being shamed, and fear of the unknown which overwhelmed them and prevented them from seeking care (Ayers, Purvis, et al., 2018). These stigmas are paralyzing to Marshallese women and prevent them from feeling empowered and educated enough to seek prenatal care.

My internship at Willow Creek Women's Hospital provided me with first-hand experience with aiding my nurses and patients throughout the birth process. Through my experience, I was able to work as a nursing assistant and shadow labor and delivery nurses as they rounded on their patients. During this time, I learned all of the factors that go into a delivery in order to ensure the safety and wellbeing of the mother and baby, as well as the importance of integrating and collaborating every level of care for the patient. I was faced with situations that required me to think critically to ensure my patient's safety, communicate effectively and therapeutically, and grow personally. It also exposed me to the health inequities faced by the Marshallese community and how they are handled in a women's hospital setting. During my 6 months of interning, I gained invaluable experience and understanding of the healthcare side of the delivery process and was privileged to witness so many life-changing moments.

As a nursing assistant, I was entrusted with the responsibility of preparing patient rooms for delivery. This included learning how to set up rooms to make them "labor and delivery ready," stocking delivery carts with specific sutures and equipment, and making delivery tables with all the necessary instruments needed for a delivery. In order to make a room ready for a

labor patient, I had to stock the room with a Panda warmer and crib, an IV pole, ultrasound and tocodynamometer transducers and other vital sign monitors, sterile gloves, gowns, towels, and personal protective equipment. I ensured delivery carts were readily available and contained all Chromic and Vicryl suture kits, Kiwi vacuums, and IUPCs (Intrauterine pressure catheter) in case they were needed during a delivery. When making delivery tables, I used sterile technique to prepare surgical instruments such as forceps, Kelly clamps, and scissors, and arranged sterile towels, laparoscopic sponges, and the placenta box on the table.

Once the room and tables were prepared, I would bring a newly admitted patient to the room, give them a gown to change into, and attach the necessary monitors. My nurse and I would then assess our patient by listening to her heart and lung sounds, checking vital signs like pulse and blood pressure, palpating for peripheral edema, checking deep tendon reflexes, and determining the baby's position. My nurse would then perform a cervical exam using a sterile glove to determine the dilation, effacement, and station of the baby. This is only done a few times before delivery, as there is a risk for infection with each exam. After this, I would help insert an IV under the supervision of my nurse if one was not already in place. If the patient had been admitted for a scheduled induction of labor (IOL), my nurse and I would begin a bolus of Lactated Ringer's through the IV in order to provide the patient with adequate fluid volume before administering either Pitocin or Cytotec. These drugs cause the uterus to contract and the cervix to ripen, meaning it softens and dilates, causing an induction of labor. It is important to monitor fetal heart rate and contraction strength, duration, and frequency during infusion of these drugs. I learned that induction through Pitocin or Cytotec should be stopped immediately if strong contractions are lasting longer than one minute at a rate of more than six contractions

every 10 minutes, as uterine tachysystole can cause decreased oxygen perfusion to the placenta. While administering these drugs, my nurse and I would make frequent assessments to the mother and continuously monitor her contractions in conjunction with the baby's heart rate. As each contraction reached its peak, we would closely watch the baby's heart rate to determine if it stayed between the normal limits of 120-160 bpm. If the heart rate increased, or accelerated, during a contraction, that meant the baby was having a positive response to the contraction. If the heart rate decreased at the same time as the peak of a contraction and then returned to normal, that indicated pressure was being applied to the baby's head which was impacting its heart rate. If the baby's heart rate decreased after the peak of the contraction and continued to stay low for an extended period of time, this would indicate a late deceleration. Late decelerations indicate that the baby is not receiving enough oxygen from the placenta, and blood perfusion to the placenta is reduced. This requires immediate intervention by the nurse to reposition the mother, administer oxygen, stop Pitocin, and notify the provider.

One important aspect of helping my patients through their labor was by pharmacological and nonpharmacological pain relief measures. I learned that pain induces stress hormones like epinephrine and norepinephrine, that make it difficult for a mother to relax, which inhibits the progression of labor and proper blood flow to the placenta. One specific pharmacologic measure for managing pain from labor is the use of an epidural, a form of anesthesia that can be chosen if labor pain is too great for the mother to bear. An anesthesiologist performs the epidural, and a pump is connected to a catheter inserted into her spine. The nurse and I would monitor the mother's blood pressure throughout the procedure, carefully checking to see if there was a sudden drop. Epidurals cause vasodilation, sometimes leading the mother's blood pressure to

drop, which can in turn impact the mother's ability to perfuse blood to the placenta. If the mother did choose an epidural, I would insert a Foley catheter into her urethra using sterile technique under the guidance of my nurse. This intervention keeps the mother from having to get up to go to the bathroom, which would put her at an increased risk of falls due to numbing of her lower abdomen and legs. Along with an epidural, there are nonpharmacologic measures to reduce pain as well. I would perform acupressure massages on mother's feet and back in order to distract from pain, play music in the room to lighten the mood, place cool rags on the mother's forehead and behind her neck, use slow breathing techniques with each contraction, help my nurse change the mother's position frequently to reduce pressure to one side, and utilize the birthing ball to help open the mother's hips and stretch the muscles that would be used for delivering her child. I enjoyed this portion of the delivery process because I could adjust my plan of care based on the mother's preferences and empower her to take charge of her delivery and birth experience. Some evidence-based interventions are standard with every labor to ensure safety, however, using these other nonpharmacologic methods shows just how individual each patient is and how her personal birth goals are unique to her.

As the mother's labor progressed, I would assist the nurse with "practice pushes" to help prime the baby for delivery. One night, I assisted my nurse with the "towel pull" method to help the mother push. I would hold one end of the towel, the mother would use both arms to grab her end, and we would both pull against each other at the building of each contraction. This action improved the effectiveness of the mother's practice pushes, and prevented her vaginal canal from tearing. Once the nurse determined the mother was ready to deliver, she notified the provider. I would bring the delivery cart and delivery table that I had prepared into the room for the

physician. I would stand by the mother and hold her leg, instructing her to take a deep, cleansing breath, then take another deep breath, hold it, and push for 10 seconds with her chin to her chest. My nurse and I would assist the mother with counting and breathing with each push. This process would be repeated until the baby was delivered. If the provider had issues with delivering the baby, I could retrieve necessary equipment such as the Kiwi suction or forceps from the delivery cart. Once the baby was born, it would be placed on the mother's chest to allow skin-to-skin interaction, an evidence-based practice that has been proven to improve infant outcomes and stabilize the infant's vital signs. The nurses who were "catching" the baby would perform APGAR (appearance, pulse, grimace, activity, and respirations) assessments at one minute and five minutes. If the baby was having trouble breathing or was not crying, it was immediately taken to the warmer, where the nurses could perform suctioning to expel secretions, administer oxygen, and stimulate the baby in an effort to make it cry. These interventions are sometimes necessary in order for the baby to oxygenate properly and allow adequate perfusion of blood to its vital organs. After the cord had been cut and delivery of the placenta had occurred, I would assist the provider by dropping sutures on the delivery table, if necessary, in case of tearing or repairing an episiotomy. My nurse would then increase the titration of the Pitocin and perform her first fundal rub in an effort to prevent postpartum hemorrhaging. After the delivery, I would count out the instruments and laparoscopic sponges to ensure nothing was left behind, would clean the delivery table, and return it to the sterilization room. My nurse and I would continue to monitor the mother's blood pressure, pulse, respiration rate, and blood loss to assess for signs of postpartum hemorrhage.

After delivery, my nurse and I would ensure our patient's epidural had worn off so we could get her up to go to the bathroom. We educated her about using a peri bottle to cleanse the perineum instead of wiping, and utilizing ice packs, witch hazel pads, and numbing spray to reduce inflammation, pain, and swelling of the perineum. We would also encourage the mother to observe how much blood was lost with each changing of her pad. Having clots that are larger than golf ball size or filling an entire pad in less than an hour are signs for concern and could indicate postpartum hemorrhage. After educating the mother and assessing her urine output, her and her baby were transferred to the postpartum unit.

There are so many aspects of the birth process that are unique to each individual that result in a positive outcome. Some differences, however, show that there are prominent health disparities and inequities in perinatal care, especially for that of Marshallese mothers. During my internship, I have seen several of the barriers mentioned previously in my own clinical experience. Some of the most prominent factors were language and cultural barriers. Several of the nurses I worked with admitted that they struggled in the area of education and assessment because they could not verbally communicate with their patients. They also admitted that they were unsure how to administer pain medications or treatments because the mothers would never admit to pain and did not show pain in their expressions and other non-verbal cues, even when they were in the active phase of labor. When I would take vital signs on my patients, those who were Marshallese often knew very little English and would give me confused gazes when I asked how they were feeling. Their culture also varied greatly from other patients we saw. Their entire family would come to see the newborn and mother and would bring food, children, and other relatives. This made it difficult to have the mother's full attention when teaching. I never directly

experienced how their culture and knowledge deficit on western healthcare applied to insurance and payment at Willow Creek, but there have been instances where patients have refused treatment because they thought it would cost them extra. I have also seen many mothers come into triage who are nine or 10 centimeters dilated upon admission because they waited until they were about to deliver to go to the hospital. There were some Marshallese women who were proficient in English, but some of the nurses would admit that the language barrier caused them to lose a connection with their patients, making them feel guilty about their lack of care. Oftentimes, I or my nurse would have to enlist the help of our Marshallese secretary, Kiki Beasha, to translate on our behalf.

I had the opportunity to sit with Kiki and briefly discuss her perspective on the barriers of care the Marshallese community receives at Willow Creek and in Northwest Arkansas. She has a unique perspective because she is from the Marshall Islands, but works in the healthcare system and sees firsthand how difficult it is for Marshallese women to access prenatal care. Kiki has lived in Northwest Arkansas for nine years and has worked as a secretary at Willow Creek for seven of those years. She stated that approximately 9% of the patients she admits to the hospital each month are from the Marshallese community. When asked for specific examples of barriers she has seen nurses encounter with caring for Marshallese patients, she explained, “There is no prenatal care, and many times they are late to their induction appointment,” which puts a strain on the nurses and physicians. She also stated that “they avoid speaking, some are nervous because there is a language and cultural barrier.” When I asked how Marshallese mothers act during labor, she stated that they go through labor “calmly, with smiling faces” and do not show any pain. “Oftentimes,” she stated, “some come to the hospital and don’t feel any pain or

contractions. They will refuse an epidural in advance because they know they do not want one.”

To close the brief interview, I asked Kiki what she thought could be done to help improve care for Marshallese mothers. “Encourage them [on] how important [it is] to get prenatal care, have them attend a [birth] workshop or educate them.” I asked if she thought there would be any difficulties or obstacles to this effort, to which she replied, “some will not know where to go for prenatal care or will not have a ride in order to get there. Having a lack of communication will be the biggest issue.” All of these responses affirmed what I have seen when working at Willow Creek. Having language barriers with no interpreters available and, oftentimes, no prenatal care, places a strain on both nursing staff and mothers.

Although there have been numerous obstacles to Marshallese mothers not receiving the care they need, solutions are still within reach. These solutions, however, need to be addressed at all levels of care. Politically, there needs to be a policy change to cover COFA migrants under Medicaid. “Restoring Medicaid for COFA migrants is a crucial part of ensuring that all Marshallese persons have access to affordable health care” (McElfish, et al., 2015). Along with adjusting Medicaid coverage, “practitioners can be important advocates. . .that will enable them to provide affordable and timely care to Marshallese patients. There is also a need to develop in-language insurance education information to help educate Marshallese patients about how to access and use insurance coverage” (McElfish, et al., 2018). Structurally, community support and program development would further enable the Marshallese people to take action with their health. The study conducted by Ayers and Purvis, et al. was used to create a cultural competency training for healthcare providers across all levels and influence policy changes that will “reduce maternal and child health disparities within the Marshallese community” (Ayers, Purvis, et al.,

2018). Programs to help educate mothers about the importance of prenatal care and health communication campaigns will impact early prenatal care, if implemented (Ayers, Purvis, et al., 2018). In order to address the language barrier, McElfish suggested hiring ancillary staff who are bilingual in Marshallese and English to bridge the communication gap and help providers better explain concepts and reinforce recommendations for improving health, as well as developing medical interpretation programs to train ancillary staff so they can be a better resource for providers (McElfish, et al., 2018). Transportation barriers can be overcome by encouraging providers to work around the family's schedule and asking when they would have the best access to transportation, as well as offering education on transportation services in the area (McElfish, et al., 2018).

Solutions such as expanding Medicaid coverage, developing prenatal programs, applying cultural competency training, enlisting the help of bilingual axillary staff, and providing transportation options will all lead to facilitating a brighter future for medical access for the Marshallese community. At Willow Creek, I hope to apply some of these changes myself by being more aware of Marshallese culture, advocating for my patients, and working with Kiki to develop a form that has basic nursing questions and responses in Marshallese. Although these interventions are small, they will hopefully cause a ripple effect that will greatly impact the quality of life for Marshallese mothers and their future generations.

This internship is not what I expected. I expected to gain knowledge on how to be a better nurse. I was forced to think critically about my patients' labor process and what interventions I would need to do as a nurse to keep them safe. I gained technical skills related specifically to labor and delivery with the assembly of delivery tables, obtaining IV access, performing fundal

rub, and taking vital signs. I learned how to effectively and succinctly communicate with my staff to ensure my patients receive the best quality care. However, through this internship, I also gained experience on how to be a better person. This internship stretched me and challenged me to look beyond basic care and interventions for patients. It exposed me to serious gaps in healthcare coverage and accessibility in our own community. These gaps need to be filled by striving to provide more inclusive policies, break social stigmas, and understand each other's cultural values and beliefs. Only through these actions will we begin to see a change. My internship experience allowed me to explore my passion for mothers and babies, and influenced me to one day become a labor and delivery nurse. I hope to use the information I learned during my time at Willow Creek Women's Hospital to push me to be a better advocate for minority groups and spread awareness of health care deficits and solutions in Northwest Arkansas.

References

- Ayers, B. L., Hawley, N. L., Purvis, R. S., Moore, S. J., & McElfish, P. A. (2018). Providers' perspectives of barriers experienced in maternal health care among Marshallese women. *Women and Birth*, 31(5). doi: 10.1016/j.wombi.2017.10.006
- Ayers, B. L., Purvis, R. S., Bing, W. I., Rubon-Chutaro, J., Hawley, N. L., Delafield, R., ... McElfish, P. A. (2018). Structural and Socio-cultural Barriers to Prenatal Care in a US Marshallese Community. *Maternal and Child Health Journal*, 22(7), 1067–1076. doi: 10.1007/s10995-018-2490-5
- McElfish, P. A. (2016). Marshallese COFA Migrants in Arkansas. *Journal of the Arkansas Medical Society*, 112(13), 259–262. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5418851/>
- McElfish, P. A., Chughtai, A., Low, L. K., Garner, R., & Purvis, R. S. (2018). 'Just doing the best we can:' health care providers' perceptions of barriers to providing care to Marshallese patients in Arkansas. *Ethnicity & Health*, 1–14. doi: 10.1080/13557858.2018.1471670
- McElfish, P. A., Hallgren, E., & Yamada, S. (2015). Effect of US Health Policies on Health Care Access for Marshallese Migrants. *American Journal of Public Health*, 105(4), 637–643. doi: 10.2105/ajph.2014.302452